Ref. 740 ILCS 110

State of Illinois
Department of Human Services

AUTHORIZATION FOR RELEASE OF INFORMATION

(1) I authorize SOUTHEASTERN ILLINOIS COUNSELING CENTERS, INC to release
(Agency/Facility/Person)

(2) _____
(Be specific, include dates of treatment/habilitation. HIV/AIDS information will not be released unless specifically requested.

(3) about _____ **Social Security Number**:_____
(Name)
Alias/Maiden Name: _____ Date of Birth: _____

(4) For the purpose of FOR DISCOVERY BEFORE TRIAL

(5) This information may be released by mail, phone, fax, electronic transmission, or verbally.

(6) Release to: RECORDS DEPOSITION SERVICE, INC.

120 W. MADISON ST., STE. 300, CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901
(complete address. If information is to be phoned or faxed, include number(s) also.)

(7) This consent is valid until (specify month, day, and year) _____

(8) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the specific information being disclosed.

(9) I understand that I may revoke this consent at any time; however, the revocation must be in writing. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(10) Refusal to consent by the individual to the release of information specified above will result in the following consequences: NO INFORMATION CAN BE SHARED

(11) It is my full understanding that the records and communications to be disclosed contain evaluation and/or habilitation/treatment information for mental health, developmental disabilities and/or alcohol or substance use/abuse and that my signature indicates my informed consent. (HIV/AIDS information only if indicated in item (2).)

(12) _____ _____
Signature of individual (age 12 or older) **Date**

(13) _____ _____
Parent/Guardian of individual (under 18 or legally disabled) **Date**

(14) _____ _____
Witness (2nd parent/guardian, if co-custodial, may sign here **Date**

NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: Under penalty of law and the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without specific authorization for such redisclosure.

INSTRUCTIONS

Complete the blanks as follows:

(1) Enter the name of the agency, facility, or person who has the information to be disclosed.

(2) Enter the specific information you wish to disclose and the dates of service, when applicable. For example, discharge summary and psychiatric examination from 5/88 hospitalization. HIV/AIDS information will not be disclosed unless specifically requested on this line. See item (11).

(3) Enter the individual's name, date of birth, social security number and aliases or maiden name to help identify inidividual.

(4) Enter the purpose or reason why the information needs to be disclosed.

(5) Identifies the manner in which the information will be released.

(6) Enter the name and address of the agency, facility, or person to whom you want the information to be sent.

(7) Enter a calendar date (month, day, and year) on which the consent is to end.

(8) and (9) Self-explanatory.

(10) Enter consequences if authorizing person refuses to consent.

(11) In accordance with the 740 ILCS 110/4 (a) only the following persons shall be entitled to consent in writing to the inspection, copying and/or release of individual's clinical record:

(a) the parent or guardian of an individual under the age of 12;
(b) the individual if he or she is 12 or older;
(c) the parent or guardian of an individual who is at least 12 but under age 18 if the individual is informed and does not object.
(d) the guardian of an individual who is 18 or older;
(e) an attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

(12) Individual to sign here IF ... Individual is 12 years of age or older and is the person requesting the release of information. Enter date individual signed on date line. No signature is required on line 13.

(13) Parent/guardian to sign here ONLY IF... the parent is the person who wants the information released and the individual who is 12 years of age through 17 years inclusive does not object OR individual is under 12 years of age; Guardian* to sign here IF... Individual is 18 years of age or older but is legally disabled OR ATTORNEY GUARDIAN AD LITEM** to sign here IF... Representing a minor 12 years of age or older in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney or Guardian ad Litem this right.

* MUST PROVIDE COURT ORDER OF GUARDIANSHIP
** MUST PROVIDE COURT ORDER GRANTING THIS RIGHT

Enter the date of parent/guardian/attorney/guardian ad litem signature on line (13).

(14) Witness to sign here, ALL AUTHORIZATIONS REQUIRE A WITNESS to attest to the identity of the person entitled to give consent (the person signing on lines 12 and/or 13.

Enter the date of witness signature on line 14.